

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 469 X

CERTIFICATE OF DEATH

02962

Reg. Dist. No. 180

1. PLACE OF DEATH:

County HartfordCity or town Tolpe
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County HartfordCity or town Tolpe
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Frank Brown

3. (b) Social Security Number

4. Sex Male5. Color or race Colored6. (a) Single, married, widowed, or divorced Widower6. (b) Name of husband or wife Alice7. Birth date of deceased (mo., day, yr.) April 10, 1871

5. (c) If alive, give age _____ years

8. AGE: Years 13 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace md.
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name Jackar Brown13. Birthplace md14. Maiden name Elizabeth Park15. Birthplace md16. Informant Family BrownAddress 1614 E Preston St.17. Burial Date thereof March 13/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Astury MethodistLocation Tolpe, Md.18. Funeral director Mrs. Robert A. Elliott, DgtAddress 1129 N. Caroline St.19. 3/13 19 45 Outkeld
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 19 45 at 6 30 p.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 19 45 to March 9 19 45 and that I last saw him alive on March 9 19 45Immediate cause of death Cancer head of pancreas

DURATION

6 months

Due to _____

Due to _____

Other conditions Pulmonary edema2 days

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Fred O Hodous, M.D.

M. D. or other

Address Edgewood, md Date signed 3-9-45

RECEIVED
APR 19 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

02963

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH:

County HarfordCity or town Aberdeen
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 yrs.

Hospital, institution, or street address where death occurred:

66 Aberdeen Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Penn County LancasterCity or town Lancaster
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2(a) If veteran, name war None

3. (a) FULL NAME

Edith E. Brown

3. (b) Social Security Number

None4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband John E. Brown6. (c) If alive, give age 49 years7. Birth date of deceased (mo., day, yr.) May 26 - 18988. AGE: Years 46 Months 2 Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Penn
(Town, county, and state)10. Usual occupation Housewife11. Industry or business None12. Name William Walker13. Birthplace Penn14. Maiden name Mary Nelson15. Birthplace Penn16. Informant Mr. John E. BrownAddress 66 Aberdeen Ave. Aberdeen Md17. Removal Date thereof Mar 6 - 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____

Location Lancaster Pa18. Funeral director Henry Tanning SonsAddress Aberdeen Md19. Mar 6 19 45 Nellie H. Piley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 6 19 45 at 12:15 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 19 42 to Mar 6 19 45and that I last saw him alive on Mar 5 19 45Immediate cause of death Thrombosis

DURATION

Due to Inoperable uterine Cainvolving uterus

Due to _____

Other conditions Hypertensive cardiovascular disease

(Include pregnancy within 3 months of death)

Major findings of operations See above

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE W B Graham M DAddress Aberdeen M. D. or other _____Date signed March 1945

RECEIVED
APR 4 1945
BUREAU V.F.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

CERTIFICATE OF DEATH

02964

Reg. Dist. No. 185

1. PLACE OF DEATH: County <u>Narford</u> City or town <u>Narford Grace</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>50 yrs</u> Hospital, institution, or street address where death occurred: <u>559 Surard St.</u> How long in hospital or institution?			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>MD.</u> County <u>Narford</u> City or town <u>Narford Grace Md.</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>559 Surard St.</u> (If rural, give LOCATION) 2.(a) If veteran, name war		
3. (a) FULL NAME <u>Julia Ann Cole</u>			3. (b) Social Security Number		
4. Sex <u>Female</u>			5. Color or race <u>Black</u>		
6. (a) Single, married, widowed, or divorced <u>Widowed</u>			6. (b) Name of husband or wife <u>Isaac Cole</u>		
7. Birth date of deceased (mo., day, yr.) <u>Oct. 1, 1875</u>			6. (c) If alive, give age _____ years		
8. AGE: Years <u>69</u> Months <u>5</u> Days <u>6</u> If less than one day _____ hrs. _____ min.			MEDICAL CERTIFICATION		
9. Birthplace <u>Narford G. Md.</u> (Town, county, and state)			20. DATE OF DEATH <u>Mar. 7</u> 19 <u>45</u> at <u>7 A.</u> M		
10. Usual occupation <u>House Duties</u>			21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>12-7-</u> 19 <u>44</u> to <u>Mar. 7</u> 19 <u>45</u> and that I last saw h. <u>alive</u> on <u>Mar. 6</u> 19 <u>45</u>		
11. Industry or business			Immediate cause of death <u>Acute myocarditis</u>		
12. Name <u>Edward Blake</u>			Duration <u>3-7-45</u>		
13. Birthplace <u>Md.</u>			Due to		
14. Maiden name <u>Mary Blake</u>			Due to		
15. Birthplace <u>Md.</u>			Other conditions <u>Polar Pneumonia</u> <u>12-7-44</u> (Include pregnancy within 3 months of death)		
16. Informant <u>Mrs. Mary Christy</u> Address <u>331 Strawberry Alley, Burial</u> Date thereof <u>Mar. 11, 1945</u> (Burial, cremation, or removal. Which?) (month) (day) (year)			Major findings of operations _____ Date of op. _____		
17. Cemetery or crematory <u>S.T. James</u>			Autopsy results _____		
18. Location <u>Narford Grace Md.</u>			PHYSICIAN: Please underline the cause to which death should be charged statistically.		
19. Funeral director <u>R. Madison Mitchell</u>			22. VIOLENCE: If death was due to external causes, fill in the following:		
Address <u>Narford Grace, Md.</u>			Accident, suicide, or homicide _____ Date of _____		
19. (Date rec'd by registrar) <u>Mar. 9</u> 19 <u>45</u> <u>G. L. Lewis M.D.</u> Registrar			Where did injury occur? _____ (City or town) _____ (County) _____ (State)		
			Injured at home, farm, industry, public place (where?) _____		
			Means of injury _____ Injured at work? _____		
			23. SIGNATURE <u>Claude L. Lawan</u> M. D. or other		
			Address <u>Narford Grace</u> Date signed <u>3-8-45</u>		

UNITED STATES DEPARTMENT OF JUSTICE
BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

RECEIVED

APR 6 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

02965

Reg. Dist. No. 185

1. PLACE OF DEATH:

County HarfordCity or town Bartholomew
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 mo

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Rural Aberdeen
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war none

3. (a) FULL NAME

Effie Cullum

3. (b) Social Security Number

none4. Sex Female5. Color or race White6.(a) Single, married, widowed, or divorced Widow6.(b) Name of husband or wife Samuel R. Cullum

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Oct 3 - 18708. AGE: Years 74 Months 6 Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Harford Co. Md.
(Town, county, and state)10. Usual occupation At home

11. Industry or business

12. Name Unknown13. Birthplace Unknown14. Maiden name Annice Porter15. Birthplace Virginia16. Informant Mrs. Dolly SherrAddress 713 Revolution St. Barode Place17. Burial Date thereof Mar 22 - 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory GraveLocation Aberdeen Md.18. Funeral director Benny Tanning Sons -Address Aberdeen Md.19. Mar 20 19 45 G. L. Lewis M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 19 - 1945 at 9:15 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1 - 1945 to Mar 19 45and that I last saw him alive on Mar 17 1945Immediate cause of death Arterio SclerosisSecondary AnemiaDue to Chronic NephritisCerebral HemorrhageDue to TraumaOther conditions Trauma

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Charles J. Feltz M.D.Address Stamford Md. Date signed 3/20/45

CERTIFICATE OF DEATH

RECEIVED

APR 6 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

02966

Reg. Dist. No. 183

1. PLACE OF DEATH:

County HarfordCity or town Jarrettsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 62 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County HarfordCity or town Jarrettsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war. _____

3. (a) FULL NAME

Joseph Elishama Eggleston

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widower6. (b) Name of husband or wife Emma Frances Blaney

7. Birth date of

deceased (mo., day, yr.) Feb 22 - 1853

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

92021

hrs.

min.

9. Birthplace Chrome Hill Harford Md

(Town, county, and state)

10. Usual occupation Merchant11. Industry or business Retired12. Name George W. Eggleston13. Birthplace Maryland14. Maiden name Mary Warner15. Birthplace Penna16. Informant Glenn E. EgglestonAddress Jarrettsville Md17. Burial Date thereof March 18 - 45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory JarrettsvilleLocation Jarrettsville Harford Co Md18. Funeral director Martha E. HuntAddress Jarrettsville Md19. March 18 1945 Thomas R. Brown

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15, 1945, at 4:00 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1944, to March 15, 1945and that I last saw him alive on March 14, 1945Immediate cause of death Heart failure

DURATION

Due to Arteriosclerosis

Due to _____

Other conditions Arteriosclerotic
gangrene of right great toe
(Include pregnancy within 2 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Charles A. Hoff

M. D. or other

Address Jarrettsville, Md Date signed March 18 1945

RECEIVED

APR 6 1945

BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

WITHIN CORPORATE LIMITS OF MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 933

CERTIFICATE OF DEATH

02967

Reg. Dist. No. 185

1. PLACE OF DEATH: County..... <u>Harford</u> City or town..... <u>Harvick Grace</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>14 days</u> Hospital, institution, or street address where death occurred: <u>Harford Memorial</u> How long in hospital or institution?..... <u>14 days</u>			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>md.</u> County..... <u>Harford</u> City or town..... <u>Harvick Grace, Md.</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>110 So Washington St.</u> (If rural, give LOCATION) 2.(a) If veteran, name war.....		
3. (a) FULL NAME <u>William H. Foster</u>			3. (b) Social Security Number		
4. Sex <u>Male</u>	5. Color or race <u>white</u>	6. (a) Single, married, widowed, or divorced <u>Widowed</u>			
6. (b) Name of husband or wife <u>Emma J. Foster</u>					
7. Birth date of deceased (mo., day, yr.) <u>Jan. 17, 1873</u>					
8. AGE: Years <u>72</u> Months <u>1</u> Days <u>12</u> It less than one day hrs. min.					
9. Birthplace <u>N. J.</u> (Town, county, and state)					
10. Usual occupation <u>Retired</u>					
11. Industry or business					
MOTHER	12. Name <u>Wm H. Foster</u>				
	13. Birthplace <u>N. J.</u>				
	14. Maiden name <u>Mary Ellen Trullinger</u>				
15. Birthplace <u>N. J.</u>					
16. Informant <u>M. Joseph L. Foster</u> Address <u>Belair Md.</u>					
17. Burial Date thereof <u>Mar. 3, 1945</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory <u>Baptist Churchyard</u> Location <u>Woodstown N. J.</u>					
18. Funeral director <u>R. Madison Mitchell</u> Address <u>Harvick Grace, Md.</u>					
19. <u>3-2</u> <u>19 45</u> <u>A. L. Lewis M.D.</u> (Date rec'd by registrar) Registrar					

MEDICAL CERTIFICATION
20. DATE OF DEATH Mar. 1 19 45 at 9:35 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 35 to Mar. 1 19 45 and that I last saw him alive on Mar. 1 19 45
 Immediate cause of death Acute Dilatation Heart
Bronchial Pneumonia
& Stupor
 Other conditions
 (Include pregnancy within 8 months of death)
 Major findings of operations Date of op.
 Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where)
 Means of injury Injured at work?
23. SIGNATURE A. L. Lewis M.D. M. D. or other
 Address Harvick Grace Md. Date signed 3/2-45

RECEIVED
MAR 7 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

CITY AND CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02968

Reg. Dist. No. 185

1. PLACE OF DEATH:

County Harford
 City or town R. F. D. 1, Havre de Grace
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? About 30 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Harford
 City or town Havre de Grace, R. F. D. 1
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R. F. D. 1 Havre de Grace
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Harriett Gaines

3. (b) Social Security Number

4. Sex Female 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Rev. W. H. Gaines
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Born in yr. of 1860
 8. AGE: Years 85 Months x Days x If less than one day _____ hrs. _____ min.

9. Birthplace Buckingham County, Va.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name See Lockitt13. Birthplace State of Va.14. Maiden name Martha15. Birthplace State of Va.16. Informant Mrs. Rosa JordanAddress R. F. D. 1 Havre de Grace, Md17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof March 28, 1945
(month) (day) (year)Cemetery or crematory Union M. E. CemeteryLocation Berdeen, Maryland18. Funeral director Elmer E. BillockAddress 556 Lewis St. Havre de Grace, Md19. 3-27 19 45 A. E. Lewis, M. D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 19 45 at 11:40 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-23-45 to 3-23-45 19 45and that I last saw her alive on 3-23-45 19 45Immediate cause of death Cerebral Hemorrhage DURATION 3-23-45

Due to

Due to

Other conditions Acute Bronchitis 3-7-45

(Include pregnancy within 3 months of death)

Major findings of operations

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Claude L. Brown M. D. or otherAddress Havre de Grace Date signed 3-27-45

RECEIVED

APR 6 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

02969

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH County... <u>Harford</u> City or town... <u>Harford</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State... <u>Maryland</u> County... <u>Harford</u> City or town... <u>Harford</u> (If outside city or town limits, write RURAL and give nearest town) Street No... <u>Junius St.</u> (If rural, give LOCATION) 2.(a) If veteran, name war			
3. (a) FULL NAME <u>Martha Frederick Galloway</u>				3. (b) Social Security Number			
4. Sex <u>Female</u>		5. Color or race <u>Negro</u>		6. (a) Single, married, widowed, or divorced <u>married</u>		MEDICAL CERTIFICATION	
6. (b) Name of husband or wife <u>Charlie Galloway</u>				20. DATE OF DEATH <u>March 17</u> 19 <u>45</u> , at <u>8 P.</u> M.			
7. Birth date of deceased (mo., day, yr.) <u>Unknown</u>				21. I CERTIFY that death occurred on the date above stated: that I attended deceased from <u>November</u> 19 <u>44</u> , to <u>March 17</u> 19 <u>45</u> , and that I last saw her alive on <u>March 17</u> 19 <u>45</u>			
8. AGE: Years <u>about 73</u>		Months <u>-</u>		Days <u>-</u>		If less than one day <u>-</u> hrs. <u>-</u> min.	
9. Birthplace <u>Annapolis Md.</u> (Town, county, and state)				Immediate cause of death <u>Coronary thrombosis</u>			
10. Usual occupation <u>House wife</u>				Due to <u>arteriosclerosis</u>			
11. Industry or business				Due to <u>Hypertension</u>			
12. Name <u>Fredrick</u>				Other conditions <u>Diabetic Mellitus</u>			
13. Birthplace <u>Maryland</u>				(Include pregnancy within 3 months of death)			
14. Maiden name <u>Caroline</u>				Major findings of operations			
15. Birthplace <u>Maryland</u>				Date of op.			
16. Informant <u>Echel Boston</u>				Autopsy results			
Address <u>Junius St, Harford</u>				PHYSICIAN: Please underline the cause to which death should be charged statistically.			
17. (Burial, cremation, or removal. Which?) <u>Burial</u>				22. VIOLENCE: If death was due to external causes, fill in the following:			
Date thereof <u>3/20/45</u>				Accident, suicide, or homicide... Date of...			
Cemetery or crematory <u>St James A.M.E.</u>				Where did injury occur? (City or town) (County) (State)			
Location <u>Harford</u>				Injured at home, farm, industry, public place (where?)			
18. Funeral director <u>Burman & Son</u>				Means of injury Injured at work?			
Address <u>Harford</u>				23. SIGNATURE <u>John M. D.</u>			
3/20/45				Address <u>Harford</u> Date signed <u>March 19</u>			
19. (Date rec'd by registrar) <u>3/20/45</u>				Registrar <u>A. L. Lewis M.D.</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

AGE

PLACE OF DEATH

SEX

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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PLACE OF DEATH

RECEIVED
APR 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

CITY'S CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02970

Reg. Dist. No. 185

1. PLACE OF DEATH:

County Hartford CoCity or town Harrods Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William S. Gilbert

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Adah E. Gilbert

7. Birth date of deceased (mo., day, yr.)

Sept 29-1873

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

71

hrs. min.

9. Birthplace

Hartford Co., Md
(Town, county, and state)

10. Usual occupation

Black Smith

11. Industry or business

MOTHER FATHER

12. Name

Martin W. Gilbert

13. Birthplace

Hartford Co., Md

14. Maiden name

Clarence Hughes

15. Birthplace

Hartford Co., Md

16. Informant

Mrs. Emma McClintock

Address

Harrods Grace, Md

17.

Burial
(Burial, cremation, or removal, Which?)

Date thereof

Mar 26/45
(month) (day) (year)

Cemetery or crematory

Thomas Run

Location

Hartford Co. near Schack's Corner Rd.

18. Funeral director

Dean & Sons

Address

Bel Air, Md

19.

Mar. 26
(Date rec'd by registrar)

19

45

G. L. Lewis M.D.
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Hartford

City or town

Harrods Grace
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Mar 24 1945 at 12:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 20 1945 to Mar 24 1945

and that I last saw him alive on

Mar 24 1945

Immediate cause of death

Due to

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

RECEIVED
APR 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1310

CERTIFICATE OF DEATH

02971

Reg. Dist. No. 184

1. PLACE OF DEATH: County..... <u>Harford</u> City or town..... <u>Frost Hill</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: How long in hospital or institution?		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>md</u> County..... <u>Harford</u> City or town..... <u>Frost Hill</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) <u>no</u> 2. (a) If veteran, name war.....	
3. (a) FULL NAME <u>Hall H. Grafton</u>		3. (b) Social Security Number <u>no</u>	
4. Sex <u>Male</u> 5. Color or race <u>White</u> 6. (c) Single, married, widowed, or divorced <u>Widower</u>		MEDICAL CERTIFICATION 20. DATE OF DEATH <u>MARCH 19</u> 19 <u>45</u> , at <u>3:15 A</u> M 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>march 1st</u> 19 <u>44</u> to <u>march 19</u> 19 <u>45</u> and that I last saw him alive on <u>march 18</u> 19 <u>45</u> Immediate cause of death <u>CHRONIC MYOCARDIAL DISEASE</u> <u>CHRONIC INTERSTITIAL NEPHRITIS</u> Due to Due to Other conditions (Include pregnancy within 3 months of death) Major findings of operations Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town)..... (County)..... (State)..... Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?.....	
6. (b) Name of husband or wife <u>Dead</u> 6. (c) If alive, give age years 7. Birth date of deceased (mo., day, yr.) <u>Oct. 14, 1856</u> 8. AGE: Years <u>88</u> Months <u>5</u> Days <u>5</u> If less than one day..... hrs. min. 9. Birthplace <u>Harford Co., Md.</u> (Town, county, and state) 10. Usual occupation <u>Retired</u> 11. Industry or business <u>Farmer</u>		DURATION <u>1 1/2 yrs</u> <u>></u>	
FATHER 12. Name <u>Bennett Grafton</u> 13. Birthplace <u>Ireland</u> MOTHER 14. Maiden name <u>Unknown</u> 15. Birthplace <u>Ireland</u>		16. Informant <u>Mrs. Hattie Timberlake</u> Address <u>Magnolia Harford Co., Md.</u> 17. Burial (Burial, cremation, or removal. Which?) <u>Burial</u> Date thereof <u>March 21, 1945</u> (month) (day) (year) Cemetery or crematory <u>Vernon Cem</u> Location <u>Harford Co., Md.</u> 18. Funeral director <u>H. S. Bailey</u> Address <u>Carlington, Md.</u> <u>March 20, 45</u> <u>M. G. Kirk</u> (Date rec'd by registrar) Registrar	
23. SIGNATURE <u>Willard P. Hudson</u> M. D. or other Address <u>Frost Hill Md</u> Date signed <u>3/19/45</u>			

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

APR 10 1945

BUT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02972

Reg. Dist. No. 184

1. PLACE OF DEATH: Harford
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....MD County.....Harford
 City or town.....Harlington Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2(a) If veteran, name war.....no

3. (a) FULL NAME Margarett K. Haines 3. (b) Social Security Number no

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife John Haines
 7. Birth date of deceased (mo., day, yr.) June 17, 1855
 8. AGE: Years 89 Months 8 Days 27 If less than one day
 hrs. min.

9. Birthplace Harford Co. Md.
 (Town, county, and state)
 10. Usual occupation at home
 11. Industry or business at home
 12. Name Wm Knight
 13. Birthplace Harford Co Md.
 14. Maiden name Jane Scott
 15. Birthplace Lreland

16. Informant Mr. Wm. Main
 Address Harlington, Md. R.D.
 17. Burial, cremation, or removal (Which?) Burial Date thereof March 15, 1945
 (month) (day) (year)
 Cemetery or crematory Public Cem
 Location Harford Co. Md.
 18. Funeral director H. S. Bailey
 Address Hawthorn Grace Md.
 19. March 15, 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14, 1945, at 7 P M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Feb 20, 1945 to Mar 14, 1945
 and that I last saw him alive on Mar 13, 1945

Immediate cause of death Cerebral Hemorrhage
 Due to.....
 Due to.....

Other conditions.....
 (Include pregnancy within 8 months of death)
 Major findings of operations.....
 Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?.....
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE F. P. Snodgrass M. D. or other
 Address Barlington Md Date signed 3/15/45

RECEIVED

RECEIVED

RECEIVED
APR 10 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02973

Reg. Dist. No. 181

1. PLACE OF DEATH:

County HarfordCity or town Aberdeen Proving Ground, Md.
(If outside city or town limits, write RURAL and give nearest town)How long is above place of death? 3 Years, 2 months

Hospital, institution, or street address where death occurred:

Station Hospital, A.P.G., Md.How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Aberdeen
(If outside city or town limits, write RURAL and give nearest town)Street No. C-1-1/4 Grant Avenue
(If rural, give LOCATION)2.(a) If veteran, name war World War I

3. (a) FULL NAME

William Russell Heller

3. (b) Social Security Number

257-07-0029

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Margaret Wills

7. Birth date of

deceased (mo., day, yr.)

5 December 18956. (c) If alive, give age 43 years

8. AGE:

Years

Months

Days

If less than one day

49317

hrs.

min.

9. Birthplace Philadelphia, Pennsylvania

(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER

12. Name

Jacob Heller

13. Birthplace

Philadelphia, Pennsylvania

MOTHER

14. Maiden name

Unknown

15. Birthplace

Unknown16. Informant The SurgeonAddress Sta. Hosp. A.P.G., Md.17. Burial
(Burial, cremation, or removal. Which?)Date thereof March 27, 1945
(month) (day) (year)

Cemetery or crematory

National

Location

Baltimore, Md.

18. Funeral director

Address

Henry Tarrington & Sons
Aberdeen, Md.19. March 26, 1945
(Date rec'd by registrar)Nellie H. Riley
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 March 1945, at 0238 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

VIEWEDand that I last saw him alive on 23 March 1945

Immediate cause of death

Cerebral Hemorrhage

DURATION

Due to Hypertensive Cardio-vascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

Confirm diagnosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

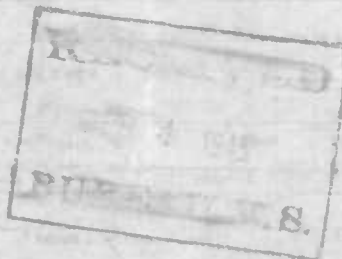
Means of injury

Injured at work?

23. SIGNATURE

Gerald C. Palmer M.D.
Deputy Medical Examiner
Harford County
Address Box 4 in Date signed 3/23/45

RECEIVED
MAR 28 1945
BUREAU V.S.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 957

CERTIFICATE OF DEATH

02974

Reg. Dist. No. 185

1. PLACE OF DEATH:

County Harford
City or town Howe de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? approx. 10 days
Hospital, institution, or street address where death occurred:
Harford Memorial Hospital
How long in hospital or institution? approx. 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Harford
City or town Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Addison Jones

3. (b) Social Security Number

212-16-2360

4. Sex Male 5. Color or race Negro 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Mary Jones
6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Jan. 28, 1878
8. AGE: Years 67 Months 1 Days 21 If less than one day _____ hrs. _____ min.

9. Birthplace Harford Co., Md.
(Town, county, and state)
10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Sylvester Jones
13. Birthplace Maryland
MOTHER 14. Maiden name Mary Washington
15. Birthplace Maryland

16. Informant Mary Jones
Address Aberdeen Md

17. Burial Burial Date thereof March 26, 1945
(Burial, cremation, or other) (month) (day) (year)
Cemetery or crematorium Green Spring Cem.
Location Harford Co., Md.

18. Funeral director H. S. Bailey
Address Parlington, Md.

19. March 21, 1945 A. L. Lewis M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-21-45 at 2:31 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-12-45 to 3-21-45 and that I last saw him alive on 3-21-45

Immediate cause of death _____ DURATION _____
Chronic Passive Congestion 2 wks.
Due to Rheumatic Heart Disease
(Insertion)
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE Charles H. Ligon M.D. M. D. or other _____
Address Howe de Grace Md. Date signed 3-21-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

RECEIVED
APR 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WITH CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02975

Reg. Dist. No. 185

1. PLACE OF DEATH:

County HarfordCity or town State de Grace
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 ds.

Hospital, institution, or street address where death occurred:

Harford Memorial HospitalHow long in hospital or institution? 4 ds.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Aberdeen
(If outside city or town limits, write RURAL and give nearest town)Street No. -
(If rural, give LOCATION)2.(a) If veteran, name war none

3. (a) FULL NAME

Irlo T. King

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Thomas O. King6.(c) If alive, give age 50 1/2 years

7. Birth date of

deceased (mo., day, yr.)

JAN. 29, 1894

8. AGE:

Years

Months

Days

If less than one day

51110

hrs.

min.

9. Birthplace

Rockwood, Tenn.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

James S. Lindell

13. Birthplace

Tenn.

14. Maiden name

Jane Doughty

15. Birthplace

Tenn.

16. Informant

Mr. Tho. O. King

Address

Aberdeen, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof Mar. 12, 1945
(month) (day) (year)

Cemetery or crematory

Oak Grove - Wise, Co.

Location

Norton, Virginia

18. Funeral director

Henry Taring House

Address

Aberdeen, Md.

19.

(Date rec'd by registrar)

Mar. 12, 1945 H. L. Lewis, Jr.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11, 1945 at 8 15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar. 8, 1945 to Mar. 11, 1945and that I last saw her alive on Mar. 11, 1945

Immediate cause of death

DURATION

Hepatic insufficiency
Due to Secondary Carcinoma of Liver
Due to Carcinoma of Stomach6 days
?
?

Other conditions

(Include pregnancy within 8 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Charles H. Ligon MD
Harold Grace MD
M. D. or other
Address Harold Grace MD Date signed 3-11-45

RECEIVED

APR 6 1945

BUREAU V.S.

PLEASE WRITE PLAINLY IN INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal to other place)

Date thereof

(month) (day) (year)

Cemetery or crematorium

Location

18. Funeral director

Address

19. Mar. 28

19. 45

Bertha B. Knight

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Mar. 27 1945 at 7 A. M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar. 6 1945 to Mar. 27 1945

and that I last saw him alive on Mar. 26 1945

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

21

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E. P. Sweeney

M. D. or other

Address: Harlington Md

Date signed 3/29/45

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
JUN 5 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

02976

1. PLACE OF DEATH:

County HarfordCity or town Harford de Grace
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 hrs. 20 min.

Hospital, institution, or street address where death occurred:

Harford Memorial HospitalHow long in hospital or institution? 9 hrs. 20 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Perryman
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Margaret W. Nelson

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

single

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 19438. AGE: Years 1 Months 3 Days 13 It less than one day _____ hrs. _____ min.9. Birthplace Md.
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name Rent Nelson13. Birthplace Indiana14. Maiden name Willie Johnson15. Birthplace Maryland16. Informant Mrs. Rent NelsonAddress Perryman, Md.17. Burial Date thereof Mar 19, 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory SpauldingLocation Perryman Md18. Funeral director Berry Tanning HouseAddress Chardon road19. Mar. 19 19 45 G. L. Lewis M. D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 18 19 45 6:50 am M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 17 19 45 to Mar 18 19 45and that I last saw him alive on Mar 18 19 45

Immediate cause of death _____ DURATION _____

Cerebral HemorrhageDue to hypertensiveinfantDue to Fall out of Bed

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 3/17/45Where did injury occur? Perryman (City or town) Harford (County) Md (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury Fall Injured at work? no23. SIGNATURE Charles J. Foley M.D.Address Harford Md Date signed 3/19/45

CERTIFICATE OF DEATH

RECEIVED
APR 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of birth date of deceased is shown on 2411 N. Charles St., Baltimore 1952

MARYLAND STATE DEPARTMENT OF HEALTH

02977

CERTIFICATE OF DEATH

Reg. Dist. No. 181

FWM No. G 94 MAY 15 1945

1. PLACE OF DEATH:

County Harford
City or town Aberdeen Proving Ground, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 1/2 years

Hospital, institution, or street address where death occurred:

Station Hospital, Aberdeen Prov Grd, Md.How long in hospital or institution? One day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pennsylvania County BradfordCity or town Bradford
(If outside city or town limits, write RURAL and give nearest town)Street No. 9 Boylston
(If rural, give LOCATION)2.(a) If veteran, name war ✓

3. (a) FULL NAME

Michael F. Patrick

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

6. (c) If alive, give age years7. Birth date of deceased (mo., day, yr.) April 22 September 1916

8. AGE: Years 29 Months 5 Days 14 If less than one day hrs. min.

9. Birthplace McKeesport, Pennsylvania
(Town, county, and state)10. Usual occupation Inspector11. Industry or business Ordnance Material12. Name Michael Patrick13. Birthplace -----14. Maiden name Mary15. Birthplace -----16. Informant The SurgeonAddress Station Hosp, Aberdeen Proving Grd, Md.17. Transportation Date thereof May 9 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory A. M. Schwerha Funeral HomeLocation 800 Lister Ave McKeesport, Pa.18. Funeral director Howard K. McConnaughyAddress Abingdon Maryland19. May 9 19 45 Willie H. Giley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 March 19 45 at 11:05 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 March 19 45 to 8 March 19 45and that I last saw him alive on 8 March 19 45

Immediate cause of death Traumatic amputation, right lower extremity. Disarticulation, complete, right, innominate bone.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Confirm diagnosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 8 Mar 45Where did injury occur? Aberdeen Proving Ground, Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) IndustryMeans of injury Explosion Injured at work? Yes23. SIGNATURE Louis Merves M. D. or otherAddress Sta Hosp, Aberdeen Proving Grd, Md. Date signed

I have received the remains of the above in good condition.

RECEIVED

APR 4 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 57-E

CERTIFICATE OF DEATH

Reg. Dist. No. 184

02978

1. PLACE OF DEATH:

County Harford
 City or town Forest Hill Rural
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Samuel B Poplin

3. (b) Social Security Number

NO

4. Sex

Male

5. Color of race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Nettie Poplin

7. Birth date of

deceased (mo., day, yr.)

Oct. 28, 1870

6. (c) If alive, give age

years

8. AGE:

Years

74

Months

4

Days

26

It less than one day

hrs. min.

9. Birthplace

Wilkes Co., N.C.

10. Usual occupation

Farmer

11. Industry or business

Dairy

12. Name

Geo. Poplin

13. Birthplace

Wilkes Co., N.C.

14. Maiden name

Rebecca Peritz

15. Birthplace

Wilkes Co., N.C.

16. Informant

Mr. Sammie Poplin

Address

Forest Hill, Md. Rural

17. Removal

March 25, 1943

18. Funeral director

H. S. Bailey

Address

Wilmington, Md.

19. (Date rec'd by registrar)

March 24, 1943

Registrar

M. D. Firk

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County HarfordCity or town Forest Hill Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

NO

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 23, 1945 at 7:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 15, 1944 to Mar. 23, 1945and that I last saw him alive on Mar. 22, 1945

Immediate cause of death

Enlargement of prostate gland

Due to

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. P. SnodgrassAddress Wilmington, Md. M. D. or otherDate signed 3/24/45

RECEIVED

APR 10 1945

BUT-1-12



2411 N. Charles St., Baltimore (19)

02979

Reg. Diat. No. 761

1. PLACE OF DEATH: County <u>Harford</u> City or town <u>Rural Chesden</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>94 mo.</u> Hospital, institution, or street address where death occurred: How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Harford</u> City or town <u>Rural Chesden</u> (If outside city or town limits, write RURAL and give nearest town) Street No. (If rural, give LOCATION) 2. (a) If veteran, name war			
3. (a) FULL NAME <u>James E. Preston</u>				3. (b) Social Security Number			
4. Sex <u>Male</u> 5. Color or race <u>White</u> 6. (a) Single, married, widowed, or divorced <u>Widowed</u>				MEDICAL CERTIFICATION			
6. (b) Name of husband or wife <u>Georgia E. Gallion</u>				20. DATE OF DEATH <u>March 18</u> 19 <u>45</u> , at <u>5:30 P.M.</u>			
7. Birth date of deceased (mo., day, yr.) <u>March 16-1851</u> 6. (c) If alive, give age..... years				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>June</u> 19 <u>44</u> to <u>March</u> 19 <u>45</u> and that I last saw him alive on <u>March 18</u> 19 <u>45</u>			
8. AGE: Years <u>94</u> Months <u>2</u> Days <u>2</u> If less than one day..... hrs. min.				Immediate cause of death <u>Uremia</u>			
9. Birthplace <u>Harford Co. Md.</u> (Town, county, and state)				Due to <u>Chronic Nephritis</u>			
10. Usual occupation <u>Cannery & Farmer</u>				Due to <u>arterio-sclerotic C.V. Disease 20 yrs.</u>			
11. Industry or business <u>Retired</u>				Other conditions			
12. Name <u>J. Henry Preston</u>				(Include pregnancy within 3 months of death)			
13. Birthplace <u>Harford Co. Md.</u>				Major findings of operations..... Date of op.			
14. Maiden name <u>Eliza Jane Cullum</u>				Autopsy results.....			
15. Birthplace <u>Harford Co. Md.</u>				PHYSICIAN: Please underline the cause to which death should be charged statistically.			
16. Informant <u>Mrs. William M. Tobin</u>				22. VIOLENCE: If death was due to external causes, fill in the following:			
Address <u>Aberdeen Md. D. F. H.</u>				Accident, suicide, or homicide..... Date of			
17. <u>Burial</u> Date thereof <u>Mar 21-1945</u> (month) (day) (year)				Where did injury occur? (City or town) (County) (State)			
Cemetery or crematory <u>Wesleyan Chapel</u>				Injured at home, farm, industry, public place (where?)			
Location <u>Near Aberdeen Md.</u>				Means of injury Injured at work?			
18. Funeral director <u>Henry Tanning Sons</u>				23. SIGNATURE <u>J. R. Ruff</u> M. D. or other			
Address <u>Aberdeen Md.</u>				Address <u>Churchville Md.</u> Date signed <u>March 19</u>			
19. <u>Mar 20</u> 19 <u>45</u> <u>Nellie D. Giles</u> (Date rec'd by registrar) Registrar							

RECEIVED

APR 4 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

02980

Reg. Dist. No. 185

1. PLACE OF DEATH: County <u>Harford</u> City or town <u>Harford</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>20 yrs.</u> Hospital, institution, or street address where death occurred: <u>653 Bourdon St.</u> How long in hospital or institution?			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>MD.</u> County <u>Harford</u> City or town <u>Harford</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>653 Bourdon St.</u> (If rural, give LOCATION) 2.(a) If veteran, name war										
3. (a) FULL NAME <u>Walter Colfax Sampson</u>			3. (b) Social Security Number										
MEDICAL CERTIFICATION													
4. Sex <u>Male</u>			5. Color or race <u>White</u>										
6. (a) Single, married, widowed, or divorced <u>Widowed</u>													
6. (b) Name of husband or wife <u>Annice L. Sampson</u>													
6. (c) If alive, give age _____ years													
7. Birth date of deceased (mo., day, yr.) <u>Sept. 27, 1876</u>													
8. AGE: <table border="1"> <tr> <td>Years</td> <td>Months</td> <td>Days</td> <td>If less than one day</td> </tr> <tr> <td><u>68</u></td> <td><u>5</u></td> <td><u>11</u></td> <td>hrs. _____ min. _____</td> </tr> </table>						Years	Months	Days	If less than one day	<u>68</u>	<u>5</u>	<u>11</u>	hrs. _____ min. _____
Years	Months	Days	If less than one day										
<u>68</u>	<u>5</u>	<u>11</u>	hrs. _____ min. _____										
9. Birthplace <u>Harford Co. Md.</u> (Town, county, and state)													
10. Usual occupation <u>Carpenter</u>													
11. Industry or business													
12. Name <u>Zachary Taylor Sampson</u>													
13. Birthplace <u>Md.</u>													
14. Maiden name <u>Sarah Louise Mitchell</u>													
15. Birthplace <u>Md.</u>													
16. Informant <u>Mrs. E. L. Simpson Singleton</u> Address <u>653 Bourdon St. Harford Md.</u>													
17. Burial <u>Rock Run</u> (Burial, cremation, or removal. Which?) Date thereof <u>Mar. 13, 1945</u> (month) (day) (year) Cemetery or crematory <u>Rock Run</u> Location <u>Harford Co. Md.</u>													
18. Funeral director <u>R. Madison Mitchell</u> Address <u>Harford Co. Md.</u>													
19. <u>Mar. 13</u> 19 <u>45</u> <u>G. L. Lewis M. D.</u> (Date rec'd by registrar) Registrar													
20. DATE OF DEATH <u>Mar. 10</u> 19 <u>45</u> at <u>7 P.</u> M.													
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Mar. 3</u> 19 <u>45</u> to <u>Mar. 10</u> 19 <u>45</u> ; and that I last saw him alive on <u>Mar. 10</u> 19 <u>45</u> .													
Immediate cause of death <u>Cardiac Insufficiency</u> <u>Myocarditis (Chronic)</u> Due to _____ Due to _____ Other conditions _____ (Include pregnancy within 3 months of death)													
Major findings of operations _____ Date of op. _____													
Autopsy results _____													
PHYSICIAN: Please underline the cause to which death should be charged statistically.													
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) _____ (County) _____ (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____													
23. SIGNATURE <u>[Signature]</u> <u>[Signature]</u> M. D. or other _____ Address <u>Harford Md.</u> Date signed <u>3/13/45</u>													

RECEIVED

APR 6 1945

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

02981

Reg. Dist. No. 183

1. PLACE OF DEATH:

County HarfordCity or town Borrisville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County HarfordCity or town Borrisville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

EVANS William Seitz

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married6. (b) Name of husband or wife Barrie H. Seitz6. (c) If alive, give age 75.5 years

7. Birth date of deceased (mo., day, yr.)

March 31 1889

8. AGE:

Years

Months

Days

If less than one day

571120hrs.min.

9. Birthplace

Borrisville MD
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

MD 23
(Date rec'd by registrar)1945 Thomas R. Brown
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1945 at 5A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____ to _____ 19____
and that I last saw him _____ alive on _____ 19____

Immediate cause of death

Coronary occlusion

DURATION

Instant

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

Address Bethesda, Md. Date signed 3/20/45Ronald C. Palmer M.D.
Public Medical Examiner
Harford County
M. D. or other _____

RECEIVED TO THE BUREAU OF INVESTIGATION

RECEIVED TO THE BUREAU OF INVESTIGATION

RECEIVED TO THE BUREAU OF INVESTIGATION

RECEIVED
APR 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Pa*

CERTIFICATE OF DEATH

02982

Reg. Dist. No. *183*

1. PLACE OF DEATH:

County *White Hall*City or town *White Hall*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Pa* County *White Hall*City or town *White Hall*
(If outside city or town limits, write RURAL and give nearest town)Street No. *183*
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Clara E. Smith

3. (b) Social Security Number

*None*4. Sex *Female* 5. Color or race *Black* 6.(a) Single, married, widowed, or divorced *Widowed*6.(b) Name of husband or wife *Lloyd E. Smith*

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) *Feb 22 1849*8. AGE: Years *96* Months *0* Days *20* If less than one day _____ hrs. _____ min.9. Birthplace *Frederick Md*
(Town, county, and state)10. Usual occupation *Housewife*11. Industry or business *Housekeeping*12. Name *Boyd Melton*13. Birthplace *Frederick Md*14. Maiden name *Went Brown*15. Birthplace *Went Brown*16. Informant *Garry Smith*Address *White Hall Md*17. *Burial* Date thereof *March 18, 1945*
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory *Pine Grove*Location *Stone Md*18. Funeral director *H. Norway*Address *Franklin Ave Pa*19. *March 18* 19 *45* *Thomas R. Brown*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *March 15* 19 *45* at *2:00* P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Mar. 4* 19 *45* to *Mar. 15* 19 *45*and that I last saw him alive on *March 14* 19 *45*Immediate cause of death *myocarditis**+ chronic bronchitis**arteriosclerosis etc*Due to *General infirmities of**old age*Due to *old age*

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings at operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE *Norman H. Geminio, M.D.*Address *Stewartstown, Pa* Date signed *Mar 16, 1945*

RECEIVED

APR 6 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CITY OF BALTIMORE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

02983

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH

County Harford
 City or town Bel Air
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Shelton Memorial HospitalHow long in hospital or institution? 5 weeks - 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford
 City or town Bel Air
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Kenmore Avenue
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Robert Stewart Taylor

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

M

6.(b) Name of husband or wife

Ella Taylor

7. Birth date of

deceased (mo., day, yr.)

8-8-10

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

7474

hrs.

min.

9. Birthplace

Taylor, Virginia
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

FATHER

12. Name

John Taylor

13. Birthplace

Virginia

MOTHER

14. Maiden name

Matilda Wallace

15. Birthplace

Virginia

16. Informant

Homer Taylor - son

Address

Bel Air, Md.

17.

Burial

Date thereof

Mar 16 1945
(month) (day) (year)

Cemetery or crematory

mt Zion

Location

Fountain Green

18. Funeral director

H Howard Bell

Address

Fawn Grove York Co Pa

19.

3-13

19

45C. L. Lewis M.D.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1945 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1945 to 1945and that I last saw him alive on 1945

Immediate cause of death

Moist gangrene R thighDue to Fracture R thigh

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 2/3/45Where did injury occur? Bel Air Harford Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HighwayMeans of injury Hit by auto Injured at work? noSignature Gerald E. Palmer MD
County Medical ExaminerAddress Bel Air, Md. M. D. or other Harford CountyDate signed 3/13/45

RECEIVED

APR 6 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

02984

Reg. Dist. No. 184

1. PLACE OF DEATH: Harford
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
WILLIAM T. TAYLOR

3. (b) Social Security Number

4. Sex.....
Male
 5. Color or race.....
White
 6. (a) Single, married, widowed, or divorced.....
Married

8. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....
March 8, 1871
 6. (c) If alive, give age..... years

8. AGE: Years..... Months..... Days..... If less than one day..... hrs..... min.
74.....5.....

9. Birthplace.....
Harford Co., Md.
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial.....

(Burial, cremation, or other. When?)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

March 14, 1945.....

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....March 13.....1945.....at.....6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....March 13.....1945.....to.....Mar 13.....1945.....
 and that I last saw him.....alive on.....19.....

Immediate cause of death.....Cerebral Hemorrhage.....
 DURATION.....Instant.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....Willard P. Hudson..... M. D. or otherAddress.....Forest Hill Md..... Date signed.....3/13/45.....

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH

RECEIVED

APR 10 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of **MARYLAND STATE DEPARTMENT OF HEALTH**
approximate age of deceased is

2411 N. Charles St., Baltimore

02985

shown on

FILM NO. G 94 MAY 15 1945

CERTIFICATE OF DEATH

Reg. Dist. No. 184

1. PLACE OF DEATH:

County Unknown

City or town Unknown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)

Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

Body found in Conowingo Dam March 9, 1945

3.(b) Social Security Number

4. Sex Female

5. Color or race White

6.(a) Single, married, widowed, or divorced

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 19..... at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

Pending investigation

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

Derald C. Palmer M.D.

23. SIGNATURE.....
Physician Medical Examiner

Harford County M. D. or other

Address..... Date signed 3/10/45

16. Informant

Address

17. Burial Date thereof March 11, 1945

(Burial, cremation, or removal of body)

(month) (day) (year)

Cemetery or crematory Harford Co. Md.

Location Harford Co. Md.

18. Funeral director A.S. Bailey

Address Harford Co. Md.

19. March 10, 1945 Registrar

(Date rec'd by registry)

Registrar

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

WITNESSED BY

RECEIVED

APR 10 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02986

P

CERTIFICATE OF DEATH

Reg. Dist. No. 185

FILM No. G 94 MAY 15 1945

1. PLACE OF DEATH:

County... Harford
City or town... Harre DeGrace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred:
Harford Memorial Hosp.
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... md County... Harford
City or town... Harre DeGrace
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Henry Wacker

3. (b) Social Security Number

none

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Single

8. (b) Name of husband or wife

—

7. Birth date of deceased (mo., d., yr.) July 24, 1884

6. (c) If alive, give age years

8. AGE: Years 61 Months 60 Days 7 It less than one day 27 hrs. min.

9. Birthplace... Baltimore
(Town, county, and state)

10. Usual occupation... Labor

11. Industry or business

12. Name... Henry Wacker

13. Birthplace... unknown

14. Maiden name... Elizabeth

15. Birthplace... unknown

16. Informant... Mrs. Harlowe

Address 106 S. Curley St.

17. Burial Date thereof Mar 22 1945
(Burial, cremation, or removal, Whight) (month) (day) (year)

Cemetery or crematory... Oaklawn

Location... Eastern ave

18. Funeral director... S. Walter May

Address 619 N. Boulevard St.

19. 3/21 19 45 Accepted
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... March 19 19 45 at 11:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19..... to 19.....
and that I last saw him alive on 19.....

Immediate cause of death

Intracranial hemorrhage 2 days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... accident Date of... 3/18/45

Where did injury occur? Abandonment Harford md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Highway

Means of injury Hit by car Injured at work? no

Gerald C. Palmer M.D. or other

23. SIGNATURE... Deputy Medical Examiner
Harford County

Address... 211 N. 2nd Date signed 3/20/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of birth date of deceased is shown on 2411 N. Charles St., Baltimore *USA*

MARYLAND STATE DEPARTMENT OF HEALTH

02987

FILM No. G 94 MAY 15 1945

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County *Harford*
City or town *Harford Grace*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

302 Revolution St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *MD* County *Harford*
City or town *Harford Grace*
(If outside city or town limits, write RURAL and give nearest town)

Street No. *302 Revolution St.*
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George Edward Ward

3. (b) Social Security Number

abundant Paving Roads, U.S.

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Hilda Virginia Ward

7. Birth date of deceased (mo., day, yr.)

December 18, 1880

6. (c) If alive, give age *1880* years

8. AGE:

Years *64* Months *3* Days *11* If less than one day
hrs. min.

9. Birthplace

Penn.

(Town, county, and state)

10. Usual occupation

Conductor G.P. & P.R.

11. Industry or business

U.S. Government

FATHER

12. Name

Charles Ward

13. Birthplace

Penn.

MOTHER

14. Maiden name

Elizabeth (unk.)

15. Birthplace

Penn.

16. Informant

Mrs. Hilda V. Ward.

Address

Harford Grace, MD

17. Burial

Burial Date thereof *Mar 29 1945*

(Burial, cremation, or removal, Which?)

Cemetery or crematory

Angel Hill

Location

Harford Grace, MD

18. Funeral director

R. Madison Mitchell

Address

Harford Grace, MD

19. Date rec'd by registrar

Mar 29 1945 *G. L. Lewis M.D.* Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Mar 27 1945 at *3 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 12 1943 to *Mar 27 1945*

and that I last saw him alive on *Mar 26 1945*

Immediate cause of death

unknown

Carcinoma of jaw

and jaw

Due to *Brain tumor in upper jaw*

Duration: *two years* cure & R.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Harford Grace, MD M. D. or other

Address *Harford Grace, MD* Date signed *3-29-45*

RECEIVED

APR 6 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

02988

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH

County HarfordCity or town Harwood Chase
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5-0 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Harwood Chase, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. 321 S. Washington
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

James Edward Woods

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(u) Single, married, widowed, or divorced married6.(b) Name of husband or wife Julia D. Woods6.(c) If alive, give age 78 years7. Birth date of deceased (mo., day, yr.) July 23 - 18658. AGE: Years 78 Months 7 Days 27 If less than one day hrs. min.9. Birthplace Washington D.C.
(Town, county, and state)10. Usual occupation Canning House Exp. (Retired)

11. Industry or business

12. Name James Woods13. Birthplace Washington D.C.14. Maiden name Mary?15. Birthplace Washington D.C.16. Interment Mrs. Julia D. WoodsAddress 321 S. Wash. St. Harwood Chase17. Burial Date thereof 3/25/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Angel HillLocation Harwood Chase, Md.18. Funeral director Funerary & BurialAddress Harwood Chase, Md.19. March 23 19 45 A. L. Lewis, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 19 45 at 11:55 P21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10 19 45 to March 22 19 45and that I last saw him alive on March 22 19 45Immediate cause of death hypostatic congestionDue to cerebral hemorrhageDue to arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lucia Urchert M.D.Address Harwood Chase, Md. Date signed 3/23/45

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

RECEIVED

APR 6 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02989

Reg. Dist. No. 185

1. PLACE OF DEATH:

County Harford
 City or town Sabre del Grace Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial Hosp
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford
 City or town Joppa
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Valentine Zeigler

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

February 11, 1861

8. AGE:

Years

Months

Days

If less than one day

84112

hrs.

min.

9. Birthplace

Joppa, Maryland
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Farmer

FATHER

12. Name

Nicholas Zeigler

13. Birthplace

Germany

MOTHER

14. Maiden name

?

15. Birthplace

16. Informant

Mrs C. B. Greenfield - Daughter

Address

same

17.

(Burial, cremation, or removal, which?)

Date thereof

March 26, 45
(month) (day) (year)

Cemetery or crematory

St. Stephens

Location

Gradesboro

18. Funeral director

Charles F. Gross

Address

Benson, Md.

19.

(Date rec'd by registrar)

March 24 1945

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1945 at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 13 1943 to Mar 24 1945and that I last saw him alive on 3-23-45 18.

Immediate cause of death

Cardiac InsufficiencyChronic diffusenephritis. Chronicmyocarditis

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 3-24-45

RECEIVED

APR 6 1945

BUREAU V.S.